State of California—Health and Human Services Agency
Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

November 12, 2008

Dear Administrator:

MONTHLY PAYMENT NOTICE FOR THE SKILLED NURSING FACILITY QUALITY ASSURANCE FEE

The California *Health and Safety Code* (H&S Code), Sections 1324.20 through 1324.30 requires the Department of Health Care Services (DHCS) to implement a Medi-Cal Quality Assurance Fee (QAF) program for Free-Standing Skilled Nursing Facilities Level B (FS/NF-B) and Free-Standing Skilled Adult Sub acute Nursing Facilities Level B (FSSA/NF-B).

This fee is imposed on total resident days including but not limited to: Medi-Cal Managed Care, Medicare, Health Maintenance Organizations, Private Pay, Other Insurance, Charity and Hospice. The QAF program, which became effective August 1, 2004, applies to all non-exempt FS/NF-Bs and FSSA/NF-Bs whether or not they participate in the Medi-Cal program. Facilities are required to pay the QAF to DHCS on a monthly basis. The fee is due on or before the last day of the month following the month for which the fee is imposed (H&S Code 1324.22, subdivision [a]).

Please submit the enclosed payment invoices and the calculated QAF payment for the following months:

November	December	January
Due by 12/31/08	Due by 1/31/09	Due by 2/28/09

Payment Invoices are available on the DHCS Web site at:
http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Provider bulletins and information on how the rates are set for the Quality Assurance Fee Program can be found at: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx

Please return the appropriate invoice with payment based on your facility's total resident days for the month to the following address:

Department of Health Care Services
Accounting Section/Cashiers Unit
MS 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please write your OSHPD and/or Medi-Cal provider number on the front of your check or money order to expedite the payment process.

Thank you for your cooperation with this program. If you have any questions please e-mail them to ab1629@dhcs.ca.gov, or you may contact the FS/NF-B QAF coordinator by calling (916) 650-0490.

Sincerely,

Jay C. Bagley

Jay C. Bagley, Chief
Overpayments Unit
Third Party Liability and Recovery Division

Enclosures

Skilled Nursing Facility Quality Assurance Fee – (FY08)
Payment Invoice for November 1, 2008 to November 30, 2008

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number:

Provider Number:

NPI Number:

Due Date: 12/31/2008

Total Remitted: $_____

Provider No.	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A08	0001

Total Resident Days_____ Multiply by $9.05 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____

(Please remit the total amount along with this payment Invoice by December 31, 2008 to the address above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Provider Number – Enter your facility's Medi-Cal provider number.

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $9.05 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed payment invoice along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY08)
Payment Invoice for December 1, 2008 to December 31, 2008

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number:

Provider Number:

NPI Number:

Due Date: 1/31/2009

Total Remitted: $_____

Provider No.	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A08	0001

Total Resident Days_____ Multiply by $9.05 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____

(Please remit the total amount along with this payment Invoice by January 31, 2009 to the address above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Provider Number – Enter your facility's Medi-Cal provider number.

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

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Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed form along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY08)
Payment Invoice for January 1, 2009 to January 31, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number:

Provider Number:

NPI Number:

Due Date: 2/28/2009

Total Remitted: $_____

Provider No.	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A08	0001

Total Resident Days_____ Multiply by $9.05 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____

(Please remit the total amount along with this payment Invoice by February 28, 2009 to the address above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Provider Number – Enter your facility's Medi-Cal provider number.

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $9.05 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number.

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